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**Role of Government and Markets in Reducing Health Care Costs**

Two seemingly incompatible facts underlie widespread failures to date in meaningfully reducing the costs of health care: broad recognition of the presence of significant "low-hanging fruit" with respect to reducing the costs of care (prime targets include ED overutilization readmissions/preventable admissions, preventive care, chronic disease management) coupled with the unbridled growth and increasing lack of sustainability of the overall costs of care for employers, states, and the federal government. In other words, despite the presence of a significant problem with large-scale implications both in terms of the health status of our population and the economic status of our institutions that carries with it identifiable and actionable solutions, we remain largely stuck in terms of implementing those solutions on a broad scale. The successes Massachusetts has seen in expanding access as well as the tepid response of providers to CMS' proposed regulations for the Medicare Shared Savings Program highlight both the potential and the challenges for productive government action. An examination of the central challenges that push providers to maintain the status quo rather than implement potential solutions, emerging models for successfully delivering value-based care, and the central role of financial incentives in stimulating innovation suggests several options for meaningful government action.

***Challenges for Providers***

At the core of the challenge for providers is navigating the transition from a fee-for-service, volume-based payment system to one based on value. In the absence of critical mass around the timing of the transition and the priorities in terms of reforms to be implemented, providers face a fragmented payment system with frequently incompatible incentives. Lacking is an agreed upon set of desired changes with respect to care delivery, with a consistent set of incentives to drive behavior change along those agreed-upon lines that includes support from enough of the payers with whom they do business. And because the majority of business today remains rooted in fee-for-service, improvement is thwarted. Moreover, even where performance-based reimbursement models are available in a given market (e.g., pay for performance, bundling scenarios, other risk-based models) they typically vary by payer, with the result of diffusing the impact of incentives offered and thus mitigating impact on outcomes and potential cost savings.

Added to this challenge is the cost of implementing a coordinated and performance-based approach to care. These start-up costs include the establishment of technology capable of measuring and monitoring performance at the physician level; physician time in identifying and agreeing to protocols for standardizing care; staff time in translating those protocols into practice; and frequently, the establishment of organization and governance that enables independent providers – which represent the overwhelming majority of providers in the US (vs. the vastly fewer integrated systems (e.g., Geisinger, Mayo, Kaiser) which receive disproportionately significant national attention) -- to collaborate in the provision of cross-continuum care. For example, in our work establishing hospital sponsored clinically-integrated physician networks, the typical first year start-up costs for a single hospital run $1.5-2M, with costs increasing year over year as the programs scale. Similarly, analysis of the incremental cost for initial development of a large scale, multi-stakeholder-involved patient centered medical home demonstration project estimated the costs at $7 per member per month in a community of about 200,000. (Both of these promising approaches described below.) While the size of these investments may not be deal-breakers in and of themselves for many providers, the combination of the investment in the face of continued uncertainty as to how significant the reimbursement changes will be, over what time period, provide a ready excuse for inaction.

One of our health system clients perhaps summed the challenge up best after attending one of the myriad "accountable care" conferences that exist that enumerate the investments needed to coordinate care and the reduction in inpatient revenues that would result from successful implementation: "What health care executive in his or her right mind would do this?"

***Emerging Models for Delivering Care "Accountably"***

In our practice and research, two models stand out as having significant potential to sustainably improve both costs and outcomes. The first is hospital-sponsored Clinical Integration, in which hospitals and physicians (inclusive of independent physicians) create organizations focused on increasing the value of health care through identifying evidence-based standards of care relevant to their local market, creating a cross-continuum data platform capable of measuring and monitoring physician performance against those standards and associated improvement targets, and then marketing that program to local employers and payers as a means of aligning physician incentives around the provision of the value-based care under the Federal Trade Commission's Clinical Integration safe harbor. Under this model physicians can see both improved professional fee schedules and meaningful pay for performance incentives that compensate them for the efforts required to lower the overall costs of care. Hospitals are typically willing to fund the initial infrastructure investments needed to effect these changes in exchange for agreement on the part of the physician network to focus on improving

performance in the inpatient setting that negatively impact hospital margins under fee-for-service (e.g, hospital acquired infections, generic drug utilization, device standardization, etc.) and the likely first targets for decreased hospital reimbursement moving forward (e.g., readmissions). Hospitals can see additional returns from this investment by utilizing the clinically integrated network as the choice provider for their self-funded employee health plans, thus leveraging their power as purchasers/payers of health care to drive incentive realignment and cost improvement. Notable systems who have achieved demonstrable gains in value through adopting this approach include Advocate Physician Partners in Chicago, Memorial Hermann in Houston, TX, Covenant Health Partners in Lubbock, TX, and a growing number of others.

The second promising model shares several of the same principles: a model to engage providers from across the continuum of care, the integration of new technologies to drive care coordination and performance improvement, a model for diminishing antitrust concerns, and the realignment of financial incentives to remove barriers to reform. This involves large scale, multi-stakeholder (physicians, hospitals, payers, state) demonstration projects focused on enhancing primary care, prevention, and chronic disease management. For example, the Adirondack Medical Home Demonstration (AMHD) in New York State has linked five hospitals, 223 primary care providers, seven private insurers collectively covering 90% of the commercial market (including the plan administering state employees and retirees), and state Medicaid, with Medicare soon to enter the demonstration. By adopting NCQA standards for patient-centered medical homes across virtually all of this 5-county region in Northeast New York State, the project seeks to enhance primary care physician income, increasing access, quality, and continuity of care, reducing avoidable utilization and costs, and improving the health of the community. Key to the construction of the program has been the four-year planning process leading up to it, bringing together diverse stakeholders at a scale capable of driving change and critically, establishing upfront the financial incentives for the fundamental transformation of the health care system required for success.

***Need to Migrate Financial Incentives***

It is this realignment of financial incentives *under fee-for-service* that our research and practice shows is the critical catalyst for value-based delivery system redesign and reform. While various risk-based and capitation models may achieve these reforms, the reality is that the overwhelming majority of US health care systems are not organized today to be successful under risk arrangements due to the fragmentation between providers and the lack of credible data that spans the full continuum of care. In order to make the operational changes required for successfully increasing health care value, providers must not only agree that the changes have value for patients, but be able to aggregate a critical mass of payers to support those

changes with sufficiently large incentives to get their attention. It is in stimulating that critical mass and using it to align incentives and use those incentives to fund operational changes that government may have its strongest impact.

***Role of Government in Reducing Health Care Costs***

Specifically, there are three meaningful roles – listed in likely order of near term magnitude -- that government can and should play in stimulating the adoption of delivery system reforms that can lead to meaningful reductions in health care costs.

1. In its role as ***purchaser of and payer for health care services,*** government -- on behalf of state employees, retirees, and Medicaid beneficiaries -- can bring needed scale to provider efforts to organize for the delivery of higher value health care by helping to fund the effort through value-based payment methodologies. We have seen this play out at the state level, as noted above in the New York State example (among others) as well as in municipalities seeking to decrease the cost of self-funded employee benefits costs, and it emulates the efforts of large, self funded employers across the country who are recognizing the value in sharing savings or directly funding the creation of needed infrastructure for care coordination as a means to decrease cost.
2. Governments may also play a meaningful role in ***setting policy and convening multi-stakeholder arrangements*** where otherwise the involved parties may not, on their own, come to the table to collaborate/negotiate. The opportunities for reductions in cost are large; if we are to navigate this transition successfully both the costs of building infrastructure and the benefits of reduced costs must be shared among the stakeholders (payers, providers, community) and that may require an impartial third party voice to ensure the outcomes are achieved. In this way, the government can become an active proponent and supporter of needed reforms, including through the endorsement of specific models of coordinated care as detailed in this testimony, requirements for payers around participation in value-based payment arrangements, and the authorization of specific pilots or demonstrations as appropriate.
3. Finally, as noted throughout this testimony, new information technologies that link independent providers sit at the foundation of all models of value-based care delivery. With its ability to serve as ***grant-maker***, government can fuel innovation through enabling acquisitions of transformative technologies and other one-time infrastructure investments for containing health care cost trends.